

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <i>Robert HENRY Cooper</i>						2a. DATE OF DEATH Month Day Year <i>12-22-68</i>			2b. HOUR <i>3:55 A.M.</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>8/21/1909</i>			6. AGE (In years lost birthday) <i>59</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>TALBOT</i> Md.						
10. CITY OR TOWN OF DEATH <i>EASTON</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital, PLUMBER</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>				13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>TILGHMAN</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last <i>THOMAS H. COOPER</i>						15. MOTHER'S MAIDEN NAME First Middle Last <i>VIRGINIA L. ROE</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <i>213-01-3301</i>		17. INFORMANT Address <i>MRS. ROBERT COOPER, TILGHMAN, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>470X</i> IMMEDIATE CAUSE (a) <i>Chronic obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia - Type undetermined</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cold</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>481X</i>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (his hospital) attended the deceased from <i>11:00</i> , 19 <i>68</i> , to <i>7:20</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12/21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>R. Lane Wroth, MD</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-24-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>R. LANE WROTH</i>		M. D.		22e. ADDRESS <i>ST. MICHAELS, MARYLAND 21663</i>								
23a. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>12/24/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>METHODIST</i>		23d. LOCATION (City or Town) (County) (State) <i>TILGHMAN, MD</i>						
24. FUNERAL DIRECTOR <i>Maurice E. Newman</i>				ADDRESS <i>Easton, Md.</i>		25a. REC'D BY REGISTRAR <i>DEC 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



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VA 16-41  
30M REV. 1-64

18293										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201										
CERTIFICATE OF DEATH (Duplicate)										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
EMMA VIRGINIA DADDS						12 Month 5 Day 68 Year		6:10 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
FEMALE		WHITE		MAR. 8-1890		78 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		USA				Talent Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Easton			Memorial			HOUSEWIFE		xx		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND			Q.A.		CHESTER				xx	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
JOHN H. KRAMME			LOUISE ENGEL							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
					RICHARD DADDS - STEVENSVILLE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 431.9 Massive Cerebral Hemorrhage									24 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									(b) Cerebral arteriosclerosis	
									unknown	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
331X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 12/5, 1968, to 12/5, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Robert W. Trever								22c. DATE SIGNED 12/6/68		
22d. PHYSICIAN'S NAME (Type) Robert W Trever M. D.								22e. ADDRESS Easton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		Dec. 9		LORRAINE		BALTIMORE MARYLAND				
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Edgar L. Lane - CHURCH HILL MD						JAN 13 1969		Charles Judge		

MEDICAL CERTIFICATION

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VR A 15 (4)  
30M REV. 7/68

18300		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18313	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Nellie Mae</i>		First <i>Mae</i> Middle <i>Dragoo</i> Last <i>Dragoo</i>		2a. DATE OF DEATH Month <i>Dec</i> Day <i>23</i> Year <i>1968</i>	
3. SEX <i>Female</i>		4. RACE <i>white</i>		2b. HOUR <i>6:40</i> PM	
5. DATE OF BIRTH <i>7-17-85</i>		6. AGE (In years last birthday) <i>83</i> YRS.		IF UNDER 1 YEAR MONTHS <i>05</i> DAYS <i>2</i>	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. COUNTY OF DEATH <i>Talbot</i> Md.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hosp.</i>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> 13b. COUNTY <i>Caroline</i>	
13c. CITY OR TOWN <i>Ridgely</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>None</i>	
14. FATHER'S NAME First <i>Frances A.</i> Middle <i>Dragoo</i> Last <i>Dragoo</i>		15. MOTHER'S MAIDEN NAME First <i>Levina</i> Middle <i>Stauffer</i> Last <i>Stauffer</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <i>No</i> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO. <i>215-20-1276</i>		17. INFORMANT <i>Mrs. Doris A. Howard</i>		Address <i>Ridgely, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Inanition &amp; senility</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cancer of breast with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Fall with laceration of forehead</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10/1/1968</i> <i>Jan 1967</i> <i>12/11/68</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>170X</i>					
19a. DATE OF OPERATION <i>170X</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i>12</i> Day <i>11</i> Year <i>1968</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>12/11</i> City or Town <i>1968</i> County <i>12/23</i> State <i>1968</i>	
22a. I certify that (I) (the hospital) attended the deceased from <i>12/11</i> , 19 <i>68</i> , to <i>12/23</i> , 19 <i>68</i> , that (I) (the hospital) last saw the deceased alive on <i>12/23</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>J. T. B. Ambler</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12/24/68</i>	
22d. PHYSICIAN'S NAME (Type) <i>J. T. B. Ambler</i>		22e. ADDRESS <i>Easton, Maryland 21601</i>		22f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-28-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Ridgely</i>	
23d. LOCATION (City or Town) <i>Ridgely, Maryland</i>		(County) <i>Talbot</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>John E. Boulais</i>		ADDRESS <i>Greenland Rd</i>		25a. REC'D BY REGISTRAR <i>DEC 30 1968</i>	

18313

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Item 6 Film G407 12/16/68 <sup>1</sup> MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18391

CERTIFICATE OF DEATH

18314

1. DECEASED-NAME (Type or print) <i>JENNIE W. DYES</i>		2a. DATE OF DEATH Month <i>12</i> Day <i>7</i> Year <i>68</i>		2b. HOUR. <i>10<sup>15</sup></i> M
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>April 13, 1897</i>		6. AGE (In years last birthday) <i>70<sup>7</sup></i> YRS.
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. COUNTY OF DEATH <i>TALBOT</i>		Md.		
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL</i>		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) <i>pickie factory</i>
12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Dorchester</i>	13c. CITY OR TOWN <i>Cambridge</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
13e. STREET AND NUMBER <i>Trailer Court</i>		<i>RED.</i>		
14. FATHER'S NAME First Middle Last <i>Martin Wheatley</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Rittia Short</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>213-24-4250</i>		17. INFORMANT <i>J. Elmer Dyes</i>
				Address <i>Hurlock, Md.</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <i>203 X</i> IMMEDIATE CAUSE (a) <i>Multiple myeloma</i> <i>Uncertain</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>203 X</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <i>12-5</i> , 19 <i>68</i> , to <i>12-7</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-7</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Robert W. Trever</i>		M.D. DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>12-8-68</i>
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>		M.D. ADDRESS <i>Easton, Maryland 21601</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12/10/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East New Market Cem.</i>
				23d. LOCATION (City or Town) (County) (State) <i>East New Market, Md.</i>
24. FUNERAL DIRECTOR <i>Harvey Williams</i>		ADDRESS <i>3 Federalburg hrd.</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 12 1968</i>
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>

1931

CRIMINAL RECORD



DEC 1 1930



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>15</div> <div>1</div> <div>18302</div> <div> <div>18315</div> <div> <div>MD</div> <div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>5</div> <div>6</div> <div>7</div> <div>8</div> <div>9</div> <div>10</div> <div>11</div> <div>12</div> <div>13</div> <div>14</div> <div>15</div> <div>16</div> <div>17</div> <div>18</div> <div>19</div> <div>20</div> <div>21</div> <div>22</div> <div>23</div> <div>24</div> <div>25</div> <div>26</div> <div>27</div> <div>28</div> <div>29</div> <div>30</div> <div>31</div> <div>32</div> <div>33</div> <div>34</div> <div>35</div> <div>36</div> <div>37</div> <div>38</div> <div>39</div> <div>40</div> <div>41</div> <div>42</div> <div>43</div> <div>44</div> <div>45</div> <div>46</div> <div>47</div> <div>48</div> <div>49</div> <div>50</div> <div>51</div> <div>52</div> <div>53</div> <div>54</div> <div>55</div> <div>56</div> <div>57</div> <div>58</div> <div>59</div> <div>60</div> <div>61</div> <div>62</div> <div>63</div> <div>64</div> <div>65</div> 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CHURCH OF GOD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A19 (M)  
30M REV. 1-69

<div>2</div> <div>1</div> <div>18323</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>18316</div>											
1. DECEASED-NAME (Type or print) First Middle Last THOMAS THOMSON FIRTH						2a. DATE OF DEATH Month Day Year DEC 22 1968			2b. HOUR M		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH NOV 1, 1878		6. AGE (In years last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) PENNA		7b. CITIZEN OF WHAT COUNTRY? U. S. A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.					
10. CITY OR TOWN OF DEATH RURAL TRAPPE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED			12b. KIND OF BUSINESS OR INDUSTRY REAL ESTATE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY TALBOT		13c. CITY OR TOWN TRAPPE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First Middle Last AUSTIN MONTGOMERY FIRTH				15. MOTHER'S MAIDEN NAME First Middle Last SARAH LIVEZEY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Address MRS THOMAS FIRTH TRAPPE MD						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week many yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <u>8 Dec</u> , 19 <u>68</u> , to <u>22 Dec</u> , 19 <u>68</u> , that <del>(I)</del> (we) last saw the deceased alive on <u>21 Dec</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Stephen P. Carney</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 12-22-68					
22d. PHYSICIAN'S NAME (Type) STEPHEN P. CARNEY						22e. ADDRESS EASTON, MD					
23a. BURIAL-CREATION, REMOVAL (Specify)		23b. DATE DEC 22 68		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL		23d. LOCATION (City or Town) (County) (State) WASHINGTON DC					
24. FUNERAL DIRECTOR <u>Charles Judge</u>				ADDRESS Easton, Md		25a. REC'D BY REGISTRAR DATE DEC 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

10315

CHARTER OF DEATH



DEC 2 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18301		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18317	
1. DECEASED-NAME (Type or print)			First	Middle	Last
ALICE			A.		GRATTAN
2a. DATE OF DEATH			Month	Day	Year
			12	28	68
2b. HOUR			6:55 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	
Female	WHITE	8-28-01		67 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
NEW YORK		USA		9. COUNTY OF DEATH TALBOT Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	
EASTON		MEMORIAL HOSP.		HOUSEWIFE	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN	
MARYLAND		TALBOT		ST. MICHAEL'S	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET AND NUMBER	
JOHN BEARDSLEY ALDEN		ELIZABETH SEGUINE		TALBOT ST.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address	
No		263-60-7904		Mrs. Jeanne D. Irwin, Hammononton, N.J.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART 1. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <i>pneumonia</i>					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Flu</i>					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
<i>Emphysema - severe, cor pulmonale</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1960</i> , 19 <i>60</i> , to <i>12-28</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-28</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Guy M. Reeser md</i>				22c. DATE SIGNED <i>12-30-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Guy M. Reeser</i>				22e. ADDRESS <i>St. Michael's md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>Jan 2, 1969</i>		<i>Moravian Cemetery</i>	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR DATE	
<i>Harrison E. Leonard</i>		<i>St. Michael's, Md.</i>		<i>JAN 3 1969</i>	
25b. REGISTRAR'S SIGNATURE				26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<i>Charles Judge</i>				<i>4 days</i>	

71364

COPIES OF DEATH

1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>18305</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>18318</span> </div>											
1. DECEASED-NAME (Type or print) <b>JAMES ISAAC HENRY</b>						2a. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>68</b>			2b. HOUR <b>12:00</b> M		
3. SEX <b>Male</b>		4. RACE <b>Col.</b>		5. DATE OF BIRTH <b>April 12, 1889</b>			6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.					
10. CITY OR TOWN OF DEATH <b>EASTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Carpenter</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Ridgely</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>		
14. FATHER'S NAME First Middle Last <b>Isaac Henry</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Georgia Ringold</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>223-28-8278</b>		17. INFORMANT Address <b>Willmina Henry Ridgely, Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CHRONIC RANAL FAILURE</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CHRONIC BT BRONCHITIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ACUTE MYOCARDIAL INFARCTION</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201 CHRONIC BRONCHITIS AND PULMONARY SCLEROSIS</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13</b> , 19 <b>68</b> , to <b>12/30/68</b> , that (I) (we) last saw the deceased alive on <b>12/29/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Dorsett Smith</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/30/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Dorsett Smith</b>						22e. ADDRESS <b>Easton, Maryland 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>1-2-69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Denton</b>			23d. LOCATION (City or Town) (County) (State) <b>Denton, Caroline, Md.</b>				
24. FUNERAL DIRECTOR ADDRESS <b>John E. Boulais</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 2 1969</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-66)  
30M REV. 11-66

18396				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				18319			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		Month Day Year		2b. HOUR		M	
GRACE CYNTHIA HORNEY				December 27, 1968				11:20 P			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		November 25, 1885		83 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
		USA				Talbot County				Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
St. Michaels		-----		Companion-nurse							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Caroline		Henderson							
14. FATHER'S NAME		First Middle Last		15. MOTHER'S MAIDEN NAME		First Middle Last					
James D. Horney				Grace Godwin							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No				Kennard G. Horney, Henderson, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4109		IMMEDIATE CAUSE (a)		years							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF		years							
		(b)									
		DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
4201											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 21 Dec, 1968, to 27 Dec, 1968, that (I) (we) last saw the deceased alive on 27 Dec, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
R. Lane Wroth, M.D.		12-30-68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
R. LANE WROTH, M. D.		St. Michaels, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Dec 30, 1968		Olivet Cemetery		St. Michaels, Maryland					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Harison E. Leonard, St. Michaels, Md.				JAN 3 1969		Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1/68

183207												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												18320											
1												CERTIFICATE OF DEATH																							
1. DECEASED-NAME (Type or print)						First Middle Last						2a. DATE OF DEATH						2b. HOUR																	
John						Horst						Dec. Month 21 Day Year 1968						6:35 PM																	
3. SEX				4. RACE				5. DATE OF BIRTH				6. AGE (In years lost birthday)				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 1 YEAR HOURS MIN.															
Male				White				10-5-03				65 YRS.																							
7a. BIRTHPLACE (State or foreign country)						7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. COUNTY OF DEATH						Md.											
MD						US												Talbot																	
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)						12b. KIND OF BUSINESS OR INDUSTRY																	
Easton						Memorial Hosp. EASTON, MD																													
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE						13b. COUNTY						13c. CITY OR TOWN						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						13e. STREET AND NUMBER											
MD						TALBOT						EASTON						YES						RD 2											
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																													
LASSPER HORST						HENRIETTA HOLLAND																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown						16b. SOCIAL SECURITY NO.						17. INFORMANT						Address																	
No						218-058395						MRS. JOHN HORST						EASTON, MD																	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																							
PART I. DEATH WAS CAUSED BY:																																			
3959 IMMEDIATE CAUSE (a) Acute pulmonary edema												5 days																							
DUE TO, OR AS A CONSEQUENCE OF																																			
(b) Calcific aortic stenosis												5 years																							
DUE TO, OR AS A CONSEQUENCE OF																																			
(c)																																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
4211																																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)						21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>						21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)						21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (the hospital) attended the deceased from November, 1965, to 21 Dec., 1968, that (I) (we) last saw the deceased alive on 21 Dec., 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE												22c. DATE SIGNED																							
Stephen P. Canby												12-21-68																							
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																							
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)																	
BURIAL						12/24/1968						WOODLAWN MEMORIAL PARK						EASTON, MD																	
24. FUNERAL DIRECTOR												25a. REC'D BY REGISTRAR												25b. REGISTRAR'S SIGNATURE											
Maurice E. Kunkin-Son												EASTON, MD.												DATE DEC 27 1968 Charles Judge											

MEDICAL CERTIFICATION

X

09330

RECEIVED

09330



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18308										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18321									
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR									
First Middle Last <b>GERRARD HUVERS</b>										Month Day Year <b>12 15 68</b>										Hour Min <b>4:50 PM</b>									
3. SEX <b>MALE</b>					4. RACE <b>WHITE</b>					5. DATE OF BIRTH <b>12/25/1885</b>					6. AGE (In years last birthday) <b>82</b> YRS.					IF UNDER 1 YEAR MONTHS DAYS					IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <b>Holland</b>					7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>					8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. COUNTY OF DEATH <b>Talbot</b> Md.														
10. CITY OR TOWN OF DEATH <b>EASTON</b>					11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>					12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>machinist</b>					12b. KIND OF BUSINESS OR INDUSTRY <b>self-employed</b>														
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>					13b. COUNTY <b>Talbot</b>					13c. CITY OR TOWN <b>Easton</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					13e. STREET AND NUMBER <b>622 Dover Road</b>									
14. FATHER'S NAME First Middle Last <b>Francis Huvers</b>										15. MOTHER'S MAIDEN NAME First Middle Last <b>unk</b>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown					16b. SOCIAL SECURITY NO. <b>211-32-2406</b>					17. INFORMANT Address <b>Mrs. Lena L. Huvers, 622 Dover Rd. Easton, Md.</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109 ACUTE LEFT VENTRICULAR FAILURE 12 HOURS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4201 DIABETES MELLITUS</b>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION <b>4201</b>					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>DIABETES MELLITUS</b>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>1967</b> , 19 <b>12/15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/15/68</b> , 19 <b>12/15</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE <b>C. R. W. Bain MD</b>															22c. DATE SIGNED <b>12/16/68</b>														
22d. PHYSICIAN'S NAME (Type) <b>C. R. W. BAIN</b>															22e. ADDRESS <b>210 DOVER, EASTON, MD</b>														
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>					23b. DATE <b>12/19/68</b>					23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>					23d. LOCATION (City or Town) (County) (State) <b>Easton, Talbot, Maryland</b>														
24. FUNERAL DIRECTOR <b>Jay D. Huvers</b>															25a. REC'D BY REGISTRAR <b>DEC 20 1968</b>					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~return~~ <sup>return</sup> carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

18322		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18322	
Item 13 Film 408 1/15/69 kk					
1. DECEASED-NAME (Type or print) First Middle Last <i>Araedine RUTH Kirby</i>			2a. DATE OF DEATH Month Day Year <i>12-22-68</i>		2b. HOUR <i>3A</i> M
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>SEPT 3, 1913</i>		6. AGE (In years last birthday) <i>55</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <i>MD</i>	7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>TALBOT</i> Md.		
10. CITY OR TOWN OF DEATH <i>EASTON</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i></i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MD</i>		13b. COUNTY <i>CAROLINE</i>	13c. CITY OR TOWN <i>DENTON</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>121 Butler Drive</i>
14. FATHER'S NAME First Middle Last <i>CHARLES WILLIAMSON</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>RUTH BURKE</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i></i>		17. INFORMANT Address <i>CHARLES E. KIRBY DENTON</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary edema</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary atherosclerotic h.d. disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i> <i>10 yrs</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>4201 Acute viral upper respiratory infection (flu).</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept</i> , 19 <i>58</i> , to <i>22 Dec</i> , 19 <i>68</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>20 Dec</i> , 19 <i>68</i> , and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
22b. SIGNATURE <i>Thorston Harrison M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>23 Dec 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		22e. ADDRESS <i>Easton, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIED</i>		23b. DATE <i>DEC. 23, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>DENTON</i>	
23d. LOCATION (City or Town) (County) (State) <i>DENTON CAR. MD.</i>					
24. FUNERAL DIRECTOR <i>Charles V. Moore, Denton, Maryland</i>		ADDRESS <i></i>		25a. REC'D BY REGISTRAR <i>DEC 27 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

18310		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		CERTIFICATE OF DEATH		18323	
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M
KATIE		R.		KOENIG	December 10 1968		6 45 A.
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE	WHITE		10-28-85		68		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MD		US				TALBOT Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		HOUSE IN THE PINES		HOUSE WORK			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
MD		TALBOT		EASTON		408 SULLYMAN AVE	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
WILLIAM J. COLLINS		MARY EATON				220-28-4974	
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA ASPIRATING</u> 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PROBABLE CARCINOMA OF STOMACH</u> DUE TO, OR AS A CONSEQUENCE OF <u>E OESOPHAGIA</u> (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 151X		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12/1/68	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/8/68</u> , 19 <u>68</u> , to <u>12/10/68</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>12/1/68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Donald D. Smith</u>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	
				23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
				SPRING HILL		EASTON, MD	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Maureen A. Deunman		300 EASTON, MD		DEC 12 1968		J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1-68

<div style="display: flex; justify-content: space-between;"> <span>18311</span> <span>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</span> <span>18324</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>												
1. DECEASED-NAME (Type or print) <div style="display: flex; justify-content: space-between;">First <u>Joseph</u> Middle <u>William</u> Last <u>KOPINKE</u></div>						2a. DATE OF DEATH <div style="display: flex; justify-content: space-between;">Month <u>12</u> Day <u>30</u> Year <u>1968</u></div>			2b. HOUR <u>6:30</u> M			
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <u>FEB. 4 - 1887</u>			6. AGE (In years last birthday) <u>81</u> YRS.		IF UNDER 1 YEAR MONTHS <u>81</u> DAYS <u>81</u>		IF UNDER 24 HRS. HOURS <u>81</u> MIN.	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>TALBOT</u> Md.						
10. CITY OR TOWN OF DEATH <u>EASTON</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>				12a. USUAL OCCUPATION (Kind of work, done during most of working life, even if retired.) <u>Retired</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>N.A.</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>				13b. COUNTY <u>Q. A. STEVENSVILLE</u>		13c. CITY OR TOWN <u>Q. A. STEVENSVILLE</u>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <u>XX</u>		
14. FATHER'S NAME <div style="display: flex; justify-content: space-between;">First <u>JULIUS</u> Middle <u>KOPINKE</u> Last <u>KOPINKE</u></div>			15. MOTHER'S MAIDEN NAME <div style="display: flex; justify-content: space-between;">First <u>EVA</u> Middle <u>BURKHARDT</u> Last <u>BURKHARDT</u></div>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>NO</u> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <u>705-05-2335</u>		17. INFORMANT <u>Jos. L. Kopinke</u> Address <u>1512 CRITTENDEN RD WILM, DEL</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Pneumonia</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>exposure</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) <u>486X</u>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>493X</u>												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>12</u> Day <u>27</u> Year <u>1968</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <u>12-27</u> , 19 <u>68</u> , to <u>12-30</u> , 19 <u>68</u> , that (1) (we) last saw the deceased alive on <u>12-29</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Robert W. Trever</u> M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									22c. DATE SIGNED <u>12-30-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>ROBERT W. TREVER</u>									22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE <u>JAN. 2</u>		23c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>			23d. LOCATION (City or Town) (County) (State) <u>STEVENSVILLE MD.</u>				
24. FUNERAL DIRECTOR <u>Edgar L. Lane</u> ADDRESS <u>Church Hill, Md.</u>						25a. REC'D BY REGISTRAR <u>JAN 6 1969</u> DATE			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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Handwritten signature or initials.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-55

18312		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18325	
CERTIFICATE OF DEATH					
1. DECEASED-NAME (Type or print) <i>Clarence Cannon Lord</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>14</i> Year <i>68</i>		2b. HOUR <i>9 a M</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>June 19, 1893</i>		6. AGE (In years last birthday) <i>75</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired Farmer</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <i>Maryland</i>		13b. COUNTY <i>Queen Anne</i>		13c. CITY OR TOWN <i>Queen Anne</i>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>None</i>			
14. FATHER'S NAME First Middle Last <i>James Lord</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Martha Cannon</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>no</i> or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>181-05-1235</i>		17. INFORMANT Address <i>Beulah Lord Queen Anne, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>433.9</i> IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis - old hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>332x Chronic obstructive lung disease</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>12 Dec</i> , 19 <i>68</i> , to <i>14 Dec</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>14 Dec</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Thorston Harrison M.D.</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>16 Dec 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>THORSTON HARRISON</i>		22e. ADDRESS <i>Easton Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>	
23d. LOCATION (City or Town) (County) (State) <i>Greensboro, Maryland</i>					
24. FUNERAL DIRECTOR <i>John E. Boulais</i>		ADDRESS <i>Greensboro Md</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 18 1968</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 1964  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <i>Mr. George Marshall</i>			2a. DATE OF DEATH Month <i>12</i> Day <i>5</i> Year <i>68</i>			2b. HOUR <i>10:20</i> M					
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>5/7/1912</i>		6. AGE (In years lost birthday) <i>56</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>MD</i>		7b. CITIZEN OF WHAT COUNTRY? <i>US</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talent</i> Md.					
10. CITY OR TOWN OF DEATH <i>Easton</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>PLANT LIFE INS</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MD</i>			13b. COUNTY <i>ALBERT EASTON</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>STONEY RIDGE</i>		
14. FATHER'S NAME First Middle Last <i>JAMES R. MARSHALL</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>LIDIA CHAPLIN</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> no, or unknown <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>212-18-6438</i>		17. INFORMANT Address <i>MRS. GEORGE MARSHALL, EASTON, MD</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>492X</i> <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF: (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>5371</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>12/9/1968</i> , 19 <i>1968</i> , to <i>12/9/1968</i> , 19 <i>1968</i> , that (I) (we) last saw the deceased alive on <i>12/9/1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>E. C. H. Schmitt</i>			22c. PHYSICIAN'S NAME (Type) <i>E. C. H. Schmitt</i>			22d. ADDRESS <i>Easton, MD</i>			22e. DATE SIGNED <i>6 Dec 1968</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>12/9/1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL</i>			23d. LOCATION (City or Town) (County) (State) <i>EASTON, MD</i>		
24. FUNERAL DIRECTOR <i>Maurice E. Newnam &amp; Son Easton</i>			ADDRESS <i>Easton</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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CHURCH OF BRATH

1-7-72

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 100-1  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>John</i> First Middle Last <i>McAvoy</i>					2a. DATE OF DEATH Month <i>12</i> Day <i>12</i> Year <i>68</i>			2b. HOUR <i>6:25</i> M		
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>DEC 19, 1885</i>		6. AGE (In years last birthday) <i>82</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>Penn.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.				
10. CITY OR TOWN OF DEATH <i>EASTON</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>MEMORIAL HOSPITAL</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>SALES MAN</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>TALBOT</i>		13c. CITY OR TOWN <i>EASTON</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>DOVER RD</i>	
14. FATHER'S NAME First Middle Last <i>JOSEPH McAvoy</i>					15. MOTHER'S MAIDEN NAME First Middle Last <i>AGNES NORRIS</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service) <i>-</i>			16b. SOCIAL SECURITY NO. <i>218-12-4913</i>		17. INFORMANT Address <i>Mrs Cecelia Sewell, Easton, Maryland</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>4109</i> DUE TO, OR AS A CONSEQUENCE OF <i>ASHD</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>-</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs - YEARS</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>4201 Iron deficiency anemia</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>John Knud-Hansen</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>12-12-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>John Knud-Hansen</i> M.D.					22e. ADDRESS <i>Easton, Maryland 21601</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Dec 14, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Oliver Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>St. Michaels Talbot Maryland</i>				
24. FUNERAL DIRECTOR <i>Hanson &amp; Leonard St. Michaels, Md</i> ADDRESS					25a. REC'D BY REGISTRAR DATE <i>DEC 23 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

MEDICAL CERTIFICATION



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 11-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
JANET WIMBLES MORSE						Month Day Year December 8, 1968			7:58 AM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female		White		August 2, 1878			90 YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Canada		USA				Talbot County Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
St. Michaels			Rio Vista Nursing Home			Housewife			----
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
New York			----		New York	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1100 Madison Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Frank Wimbles			Ellen Cockburn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			111-36-0527T		Mrs. Perry Schofield.		RFD #6 Baston, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4129 cerebro</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>atherosclerotic cardiac K</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebro V asd</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4221</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>many wks</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>cardiac &amp; Renal failure</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 21, 1968</i> to <i>12-8, 1968</i> , that (I) (we) last saw the deceased alive on <i>12-8, 1968</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Guy M. Reeser, Jr.</i>						22c. DATE SIGNED <i>12-8-68</i>			
22d. PHYSICIAN'S NAME (Type) GUY M. REESER, Jr., M. D.						22e. ADDRESS St. Michaels, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Cremation		Dec 9, 1968		Ft. Lincoln Cemetery		Washington, D. C.			
24. FUNERAL DIRECTOR <i>Harrison E. Leonard, St. Michaels Md.</i>						25a. REC'D BY REGISTRAR DEC 11 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18316		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18329	
Item 11 Film G407 12/23/68 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First MARY		Last Powell	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH 3/17/01	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (In years last birthday) 67 YRS.	
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Easton Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Talbot		13c. CITY OR TOWN Easton	
14. FATHER'S NAME First John		Middle Morris		Last Hines	
15. MOTHER'S MAIDEN NAME First Sarah		Middle Hines		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 213-22-6893		17. INFORMANT Lillie Harris	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE Pulmonary Edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4341		(b) CHRONIC CONGESTIVE HEART Disease		3 YRS.	
		(c) ACUTE LEFT VENTRICULAR FAILURE		1-2 hrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) LONG STANDING BRONCHIAL ASTHMA					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from JULY, 1965, to 12-11-1968, that (1) (we) last saw the deceased alive on 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard L. Tyson, M.D.				22c. DATE SIGNED 12-11-68	
22d. PHYSICIAN'S NAME (Type) RICHARD F. TYSON				22e. ADDRESS EASTON 21601 MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 14/68		23c. NAME OF CEMETERY OR CREMATORY Richards	
24. FUNERAL DIRECTOR Lewis A. Marshall		ADDRESS Easton 2nd		25a. REC'D BY REGISTRAR DATE DEC 17 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

Subject

14320



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

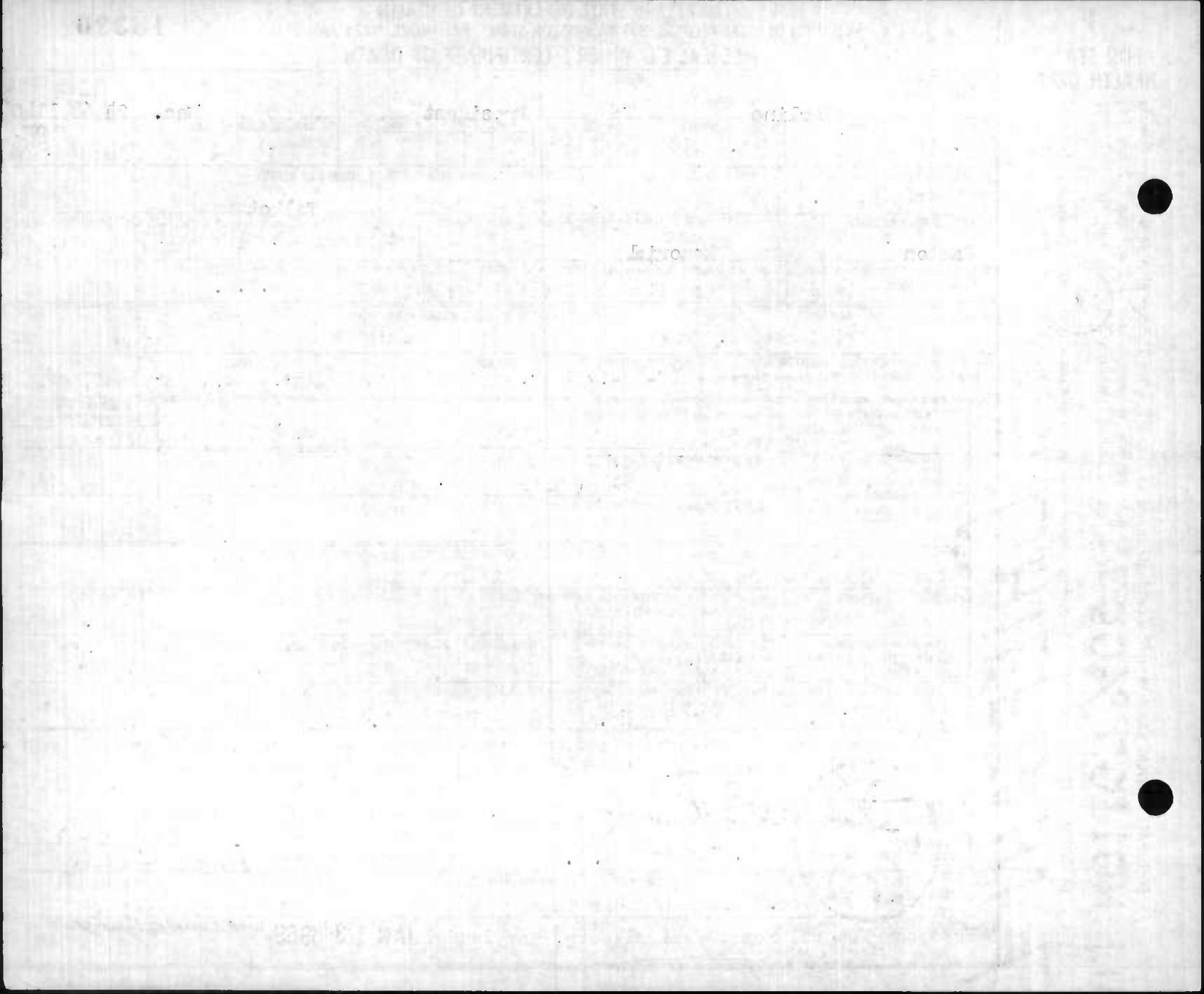
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

18317

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18330

1. DECEASED-NAME (Type or Print) <b>Earline Jones President</b>			2a. DATE KNOWN <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b. HOUR OF DEATH <input type="checkbox"/> <b>Dec. 29 1968 1140</b>		
3. SEX <b>Female</b>	4. RACE <b>C</b>	5. DATE OF BIRTH <b>Oct. 19, 1934</b>	6. AGE (In years last birthday) <b>34 YRS.</b>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>
7a. BIRTHPLACE (State or foreign country) <b>Norfolk, Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Easton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Press Operator-Maryland Plastics</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Caroline</b>	13c. CITY OR TOWN <b>Federalsburg</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME <b>Christopher C. Jones</b>			15. MOTHER'S MAIDEN NAME <b>Anzie Reid</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>229-38-1457</b>		17. INFORMANT <b>John President, Federalsburg, Maryland, RFD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral "emothorax &amp; hemo-peritoneum"</b> <b>816.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>823.4</b> (b) <b>Fracture of Sternum &amp; ribs &amp; rupture of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Automobile Accident</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>11 hours</b> <b>11 hours</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Results of Complete Autopsy As yet Or Blood Alcohol</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year <b>12:40 P.M. 12/24/68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Trees Car out of control ran off road &amp; hit</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Laurel Grive Road</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>RFD Federalsburg Caroline Maryland</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Harold B. Plummer</b>		M.D. <b>Harold B. Plummer M.D.</b>		22b. DATE SIGNED <b>12/30/68</b>	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county) <b>Prater Cordell</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Johns Cemetery</b>	
24. FUNERAL DIRECTOR <b>Frankton</b>		ADDRESS <b>Funeral Home, Federalsburg, Maryland</b>		25a. REC'D BY REGISTRAR <b>JAN 13 1969</b>	
25b. REC'D BY REGISTRAR <b>DATE</b>		25c. REC'D BY REGISTRAR <b>DATE</b>			



18318

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18331

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) W.		First W.		Middle MITCHELL		Last PRICE		2a. DATE OF DEATH 12 Month 16 Day 68 Year 8:50 A M							
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 3-13-1899				6. AGE (In years lost-birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH TALBOT Md.									
10. CITY OR TOWN OF DEATH EASTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) HOUSE IN THE PINES		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED				12b. KIND OF BUSINESS OR INDUSTRY BLDG CONTRACTOR							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY TALBOT		13c. CITY OR TOWN EASTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER							
14. FATHER'S NAME Wm Booth		First Wm		Middle Booth		Last PRICE		15. MOTHER'S MAIDEN NAME Georgia Weyrough		First Georgia		Middle Weyrough		Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs W. MITCHELL PRICE				Address EASTON MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation 1419 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 1419 (b) Hemiglossectomy radical neck dissection DUE TO, OR AS A CONSEQUENCE OF for cancer of the tongue (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 weeks															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Generalized and cerebral arteriosclerosis															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State					
22a. I certify that (I) (the hospital) attended the deceased from 12-2-68, 19, to 12-16-68, 1968, that (I) (we) last saw the deceased alive on 12-14-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE S. P. CLOUGH		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-18-68									
22d. PHYSICIAN'S NAME (Type) S. P. CLOUGH		22e. ADDRESS EASTON, MD													
23a. BURIAL/CREMATION, REMOVAL (Specify)		23b. DATE 12-20-68		23c. NAME OF CEMETERY OR CREMATORY SPRING HILL		23d. LOCATION (City or Town) (County) (State) EASTON TA MD									
24. FUNERAL DIRECTOR [Signature]		ADDRESS Easton, Md		25a. REC'D BY REGISTRAR DATE DEC 23 1968		25b. REGISTRAR'S SIGNATURE [Signature]									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>Samuel D. Royer</b>		2a. DATE OF DEATH Month <b>Dec.</b> Day <b>30</b> Year <b>1968</b>		2b. HOUR <b>5<sup>10</sup></b> M
3. SEX <b>male</b>	4. RACE <b>white</b>	5. DATE OF BIRTH <b>5-6-83</b>	6. AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Talbot</b> Md.	
10. CITY OR TOWN OF DEATH <b>Easton, Md.</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>House in The Pines</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Cordova</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Rd #1</b>
14. FATHER'S NAME First Middle Last <b>Mattathan Royer</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Amelia Dundon</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>	16b. SOCIAL SECURITY NO. <b>219-34-39621</b>	17. INFORMANT Address <b>Mrs. Samuel Royer, Cordova, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudobulbar palsy</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4500</b> (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Uncertain</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Carcinoma of the prostate with obstructive uropathy</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1-25</b> , 19 <b>65</b> , to <b>12-30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-25</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Robert W. Trever</b> DEGREE <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-30-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>ROBERT W. TREVER, M.D.</b>		22e. ADDRESS <b>BUTCHMAN'S LANE AND U. S. ROUTE 30 R. D. 3, EASTON, MARYLAND 21601</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>1/2/1969</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>	23d. LOCATION (City or Town) <b>Easton, Md.</b>	(County) (State)
24. FUNERAL DIRECTOR <b>Maurice K. Neumann, Sr.</b>	ADDRESS <b>Easton, Md.</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

THE PEOPLE OF THE STATE OF NEW YORK

6381 C. 1141



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-14  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>CLARA Dell Scott</b>						2a. DATE OF DEATH Month <b>12</b> Day <b>17</b> Year <b>68</b>			2b. HOUR <b>7:15</b> M			
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>DEC. 11, 1890</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.						
10. CITY OR TOWN OF DEATH <b>EASTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>			13b. COUNTY <b>CAROLINE</b>		13c. CITY OR TOWN <b>DENTON</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First <b>WILLIAM</b> Middle <b>CONR</b> Last <b>BE</b>						15. MOTHER'S MAIDEN NAME First <b>KATIE</b> Middle <b>MESSICK</b> Last <b>BE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>ARTHUR SCOTT, DENTON, MD</b> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> <b>3099</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General deterioration secondary to</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic brain syndrome</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>?</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>309X</b> <b>distichs mollitus</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>19</b> Month <b>12</b> Day <b>17</b> Year <b>68</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>7 Dec</b> , 19 <b>68</b> , to <b>17 Dec</b> , 19 <b>68</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>16 Dec</b> , 19 <b>68</b> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.												
22b. SIGNATURE <b>Thurston Harrison MD</b>						DEGREE <b>MD</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>19 Dec 68</b>				
22d. PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b>						22e. ADDRESS <b>Easton, Maryland</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>DEC 20, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DENTON</b>		23d. LOCATION (City or Town) <b>DENTON</b>		(County) <b>CAR</b>		(State) <b>MD</b>		
24. FUNERAL DIRECTOR <b>Charles V. Moore, Son, Denton, Md</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

*[Faint, illegible handwriting on lined paper]*

*[Faint, illegible text in the right margin]*

18331

## CERTIFICATE OF DEATH

18334

1. DECEASED-NAME (Type or print) <i>William Smith Shockley</i>		First <i>William</i> Middle <i>Smith</i> Last <i>Shockley</i>		2a. DATE OF DEATH Month <i>Dec.</i> Day <i>4</i> Year <i>1968</i>		2b. HOUR <i>3:45</i> A. M.	
3. SEX <i>Male</i>		4. RACE <i>Cau.</i>		5. DATE OF BIRTH <i>11-13-1902</i>		6. AGE (In years last birthday) <i>66</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Talbot</i> Md.	
10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Laborer</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Caroline</i>		13c. CITY OR TOWN <i>Easton</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <i>None</i>		14. FATHER'S NAME First <i>Thomas</i> Middle <i>Shockley</i> Last <i>Shockley</i>		15. MOTHER'S MAIDEN NAME First <i>Mary</i> Middle <i>Smith</i> Last <i>Smith</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>215-20-2625</i>		17. INFORMANT <i>Josephine Shockley, Goldsboro, Md.</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral thrombosis</i> <i>4339</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral arterio-sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>Unknown</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>332X</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>12-2</i> , 19 <i>68</i> , to <i>12-4</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>12-3</i> , 19 <i>68</i> , and that in (my) (aur) apinian death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Robert W. Trever</i>				DEGREE ATTENDING <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF <input type="checkbox"/> PHYS. DIRECTOR PHYS.		22c. DATE SIGNED <i>12-4-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever, M.D.</i>				22e. ADDRESS <i>Easton, Md. 21601</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>12-7-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greensboro</i>		23d. LOCATION (City or Town) (County) (State) <i>Greensboro Caroline Md.</i>	
24. FUNERAL DIRECTOR <i>John E. Boulais</i>				ADDRESS <i>Greensboro</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 9 1968</i>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR	
Baby Girl		Small		12 - 4 - 68		10:45 M	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS
Female	Col		12-3-68		— YRS.		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Md.		USA.				TALBOT Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		Memorial					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md. -		Talbot		McDaniel		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last			
Unknown				Vivian Theresa Small			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
				Vivian Theresa Small McDaniel Md. 21647			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
776.2 Respiratory Failure Prematurity							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 7735							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 12-3-68, to 12-4-68, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
John A. Hawkinson						12-9-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
John A. Hawkinson, M.D.				Easton, Md.			
23a. BURIAL CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Cremation		12/7/1968		Memorial Hospital		Easton, Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Memorial Hospital Easton, Maryland 21601				DATE DEC 12 1968		Charles Judge	

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1. DECEASED-NAME (Type or print) <i>William Francis Smith</i>			2a. DATE OF DEATH 12 Month 6 Day 1968 Year		2b. HOUR 7:35 M
3. SEX <i>Male</i>	4. RACE <i>Negro</i>	5. DATE OF BIRTH 6/1/1899		6. AGE (In years last birthday) 69 YRS.	
7a. BIRTHPLACE (State or foreign country) <i>md.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Talbot</i> Md.		
10. CITY OR TOWN OF DEATH <i>Easton</i>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>None</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>	13b. COUNTY <i>Caroline</i>	13c. CITY OR TOWN <i>Brownboro</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <i>General Del.</i>	
14. FATHER'S NAME First Middle Last <i>David Smith</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Sophronia Carter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16b. SOCIAL SECURITY NO. <i>21816-5218A</i>		17. INFORMANT Address <i>Roma Mooney, md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, rt. lower lobe</i> 303.2 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic alcoholism</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Uncertain</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>&gt; 9 days</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>3221</i>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 11-28, 1968, to 12-6, 1968 that (I) (we) last saw the deceased alive on 12-6, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Robert W. Trever</i>			DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 12-6-68	
22d. PHYSICIAN'S NAME (Type) <i>Robert W. Trever</i>			22e. ADDRESS <i>Easton, Maryland</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12/19/68	23c. NAME OF CEMETERY OR CREMATORY <i>Union</i>	23d. LOCATION (City or Town) (County) (State) <i>Goldboro, Caroline, Md.</i>		
24. FUNERAL DIRECTOR <i>Charles W. Hiel, Denton, Md.</i>	ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 9 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

1833

CHURCH OF ENGLAND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>DANIEL THOMAS STATEN</b>						2a. DATE OF DEATH Month <b>12</b> Day <b>26</b> Year <b>1968</b>			2b. HOUR <b>11</b> P. M.		
3. SEX <b>MALE</b>		4. RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>4-10-1892</b>			6. AGE (In years lost birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>TALBOT</b> Md.					
10. CITY OR TOWN OF DEATH <b>EASTON</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MEMORIAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>MARYLAND</b>				13b. CITY OR TOWN <b>CAROLINE DENTON</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>525, HIGH ST.</b>			
14. FATHER'S NAME First Middle Last <b>DANIEL T. STATEN</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>HESTER MURRAY</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <b>NO</b>				16b. SOCIAL SECURITY NO. (If give war or dates of service) <b>UNKNOWN</b>		17. INFORMANT Address <b>FAMILY - SAME AS ABOVE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>485x Anemia, cause undetermined</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>(?)</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>491x Branch of pneumonia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>26 Dec, 1968</b> , to <b>26 Dec, 1968</b> , that (I) <del>was</del> lost saw the deceased alive on <b>26 Dec, 1968</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) (did not) view the body after death.											
22b. SIGNATURE <b>Thurston Harrison MD.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>28 Dec 68</b>		
22d. PHYSICIAN'S NAME (Type) <b>THURSTON HARRISON</b>						22e. ADDRESS <b>Charles May Lane</b>					
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>			23b. DATE <b>12-30-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRINGER OYE</b>			23d. LOCATION (City or Town) (County) (State) <b>DENTON CAROLINE MD.</b>			
24. FUNERAL DIRECTOR <b>Virgil Moore &amp; Son - Denton Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JAN 3 1969</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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OFFICE OF THE ATTORNEY GENERAL

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (9)  
30M REV. 1/68

183325

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

183338

1. DECEASED-NAME (Type or print) <i>Edna N. Summers</i>			First Middle Last			2a. DATE OF DEATH 12 Month 24 Day 1968 Year			2b. HOUR 3:50 P.M.		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH 1/26/1890			6. AGE (In years last birthday) 70 YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Talbot</i>		
10. CITY OR TOWN OF DEATH <i>St. Michaels (rural)</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>St. Michaels Nursing Home</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housework</i>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Talbot</i>			13c. CITY OR TOWN <i>Easton</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <i>307 S. Washington St</i>			14. FATHER'S NAME <i>John Neunam</i>			15. MOTHER'S MAIDEN NAME <i>Ida Robinson</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i>		
16b. SOCIAL SECURITY NO. <i>214-32-5295B</i>			17. INFORMANT <i>J. Russell Summers, Easton, Md.</i>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cachexia</i> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>atherosclerotic cardio x</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>cerebro vascular</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>months</i>			PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4221</i>		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			22a. I certify that (I) (this hospital) attended the deceased from 2-19-1962 to 12-24-1968, that (I) (we) last saw the deceased alive on 12-24-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		
22b. SIGNATURE <i>Guym Preeser md</i>			22c. DATE SIGNED 12-31-68			22d. PHYSICIAN'S NAME (Type) <i>Guym Preeser Jr</i>			22e. ADDRESS <i>St Michael's md</i>		
23a. BURIAL CREMATION, REINTERMENT <i>Burial</i>			23b. DATE 12/27/1968			23c. NAME OF CEMETERY OR CREMATORY <i>Spring Hill</i>			23d. LOCATION (City or Town) (County) (State) <i>Easton, Md.</i>		
24. FUNERAL DIRECTOR <i>MAURICE E. NEUNAM &amp; SON, Easton, Md.</i>			25a. REC'D BY REGISTRAR DATE JAN 2 1969			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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VR A15 (4)  
30M REV. 11/68

183326		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		183339							
1. DECEASED-NAME (Type or print) First Middle Last Thomas Taylor				2a. DATE OF DEATH 12 Month 7 Day 68 Year		2b. HOUR 7:20 M					
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-26-1889		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Talbot Md.					
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) House In The Pines		12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY FURRIER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY TALBOT		13c. CITY OR TOWN OXFORD		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last JAMES L TAYLOR				15. MOTHER'S MAIDEN NAME First Middle Last MARY LILLIAN PORTERFIELD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 214-34-7300		17. INFORMANT Address MRS. HARRY THORPE WESTERLY, R.I.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450X Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 465X								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediately			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Atherosclerosis. Recent GI hemorrhage											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 10-25, 1968, to 12-7, 1968, that (I) (we) last saw the deceased alive on 12-5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Stephen B. Canady								DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 12-7-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE 12/19/1968		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN		23d. LOCATION (City or Town) (County) (State) WASHINGTON, D.C.					
24. FUNERAL DIRECTOR Maurice A. Newman & Son				ADDRESS EASTON, MD		25a. REC'D BY REGISTRAR DA DEC 10 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Randall E Thomas						Dec. 8 1968			12:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male		Negro		March 1, 1899			69 YRS.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Talbot Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial			Waterman			None	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		Easton				108 Talbot St. Micheals Street	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Randall Thomas Elvira Thomas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				217 28 4805		Mrs. Nannie Thomas 108 Tal. St. St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure									
4129 DUE TO, OR AS A CONSEQUENCE OF (b) atherosclerotic cardiac									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) cerebral vessel.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 12-8-68, to 12-8-68, that (I) (we) last saw the deceased alive on 12-8-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE								22c. DATE SIGNED	
Guy M. Brewer, M.D.								12-8-68	
22d. PHYSICIAN'S NAME (Type)								22e. ADDRESS	
Guy M. Brewer, Jr.								St. Michaels Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		12/10/68		Royal Oak		Royal Oak Talbot Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Dashell Funeral Home				Easton, Maryland 21601		J. Charles Judge			
				DEC 12 1968					

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LEONARDO DE DA VINCI

1492-1519

Handwritten notes and sketches, including a small diagram of a mechanical device.

Handwritten notes and sketches, including a small diagram of a mechanical device.

Handwritten notes and sketches, including a small diagram of a mechanical device.

Handwritten notes and sketches, including a small diagram of a mechanical device.

Handwritten notes and sketches, including a small diagram of a mechanical device.

Handwritten notes and sketches, including a small diagram of a mechanical device.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18328												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												18341																																															
1. DECEASED-NAME (Type or print)												First Middle Last												2a. DATE OF DEATH												2b. HOUR																																			
Roy Thomas																								12 <sup>th</sup> 15 Day 1968												M																																			
3. SEX												4. RACE												5. DATE OF BIRTH												6. AGE (In years lost birthday)												IF UNDER 1 YEAR MONTHS DAYS												IF UNDER 24 HRS. HOURS MIN.											
Male												White												10/3/1892												76 YRS.																																			
7a. BIRTHPLACE (State or foreign country)												7b. CITIZEN OF WHAT COUNTRY?												8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>												9. COUNTY OF DEATH																																			
Pa.												US																								Talbot												Md.																							
10. CITY OR TOWN OF DEATH												11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)												12a. USUAL OCCUPATION (Kind of work done during most of working life (even if retired))												12b. KIND OF BUSINESS OR INDUSTRY																																			
St. Michaels (rural)												RFD#1												Cecilian carpenter																																															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE												13b. COUNTY												13c. CITY OR TOWN												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												13e. STREET AND NUMBER																							
Md.												Talbot												St. Michaels												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												RFD#1																							
14. FATHER'S NAME First Middle Last												15. MOTHER'S MAIDEN NAME First Middle Last																																																											
Evan Thomas												Elvira																																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)												16b. SOCIAL SECURITY NO.												17. INFORMANT Address																																															
no												148-01-9073												Mrs. Roy Thomas, St. Michaels, Md.																																															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																																															
188X												Chronic myocarditis												6 min																																															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												(b) Cause of death of bladder												8 yr.																																															
												(c)																																																											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																																							
1810																																																																							
19a. DATE OF OPERATION												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)												21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																															
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												21f. LOCATION Street or R.F.D. No. City or Town County State																																															
22a. I certify that (I) (this hospital) attended the deceased from 10:15 P.M. 1968, to 10:15 P.M. 1968, that (I) (we) last saw the deceased alive on 13 Dec 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																																							
22b. SIGNATURE												22c. DATE SIGNED																																																											
R. K. Kaul (M.D.)												13-16-68																																																											
22d. PHYSICIAN'S NAME (Type)												22e. ADDRESS																																																											
23a. BURIAL, CREMATION, REMOVAL (Type)												23b. DATE												23c. NAME OF CEMETERY OR CREMATORY												23d. LOCATION (City or Town) (County) (State)																																			
Burial												12/17/1968												Olivet												St. Michaels, Md.																																			
24. FUNERAL DIRECTOR												ADDRESS												25a. REC'D BY REGISTRAR DATE												25b. REGISTRAR'S SIGNATURE																																			
MURRAY E. NEUNAM & SON												Easton, Md.												DEC 18 1968												Charles Judge																																			

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18323		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18342	
Item#5, FilmG107 12/9/68 km		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) <i>John James Toth</i>		First Middle Last		2a. DATE OF DEATH Month <i>12</i> Day <i>3</i> Year <i>1968</i>	
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>Dec. 8, 1919</i>	
7a. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		6. AGE (In years last birthday) <i>49</i> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7c. BIRTHPLACE (State or foreign country) <i>Pa.</i>		7d. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <i>Talbot</i>		10. CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Alceyaria</i>	
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>plumber and heating contr.</i>		12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> 13b. COUNTY <i>Caroline</i>	
13c. CITY OR TOWN <i>Federalsburg</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Long Branch Road</i>	
14. FATHER'S NAME First Middle Last <i>John J. Toth Sr.</i>		15. MOTHER'S MAIDEN NAME First Middle Last <i>Cecelia Dekan</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>yes</i> (If yes give war or dates of service) <i>W. W. II</i>	
16b. SOCIAL SECURITY NO. <i>194-10-7582</i>		17. INFORMANT <i>Mrs. Virginia L. Toth</i>		Address <i>Federalsburg, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1621 Autastatic carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>lung</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (?) (?)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>163x</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>30 Oct</i> , 19 <i>68</i> , to <i>3 Dec</i> , 19 <i>68</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>3 Dec</i> , 19 <i>68</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.		22b. SIGNATURE <i>Hurston Harrison MD.</i> DEGREE <i>MD.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>3 Dec 68</i>	
22d. PHYSICIAN'S NAME (Type) <i>HURSTON HARRISON</i>		22e. ADDRESS <i>Carbon Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		23b. DATE <i>12-10-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cemetery</i>	
23d. LOCATION (City or Town) <i>Federalsburg Md.</i>		(County) <i>Talbot</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR <i>James Williams - Federalsburg, Md.</i>		ADDRESS		25a. RECEIVED BY REGISTRAR <i>DEC 10 1968</i> 25b. REGISTRAR'S SIGNATURE <i>J. B. Jones</i>	

1851

RECORDS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA FORM 104  
304A REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18330

CERTIFICATE OF DEATH

18343

1. DECEASED-NAME (Type or print) First Middle Last <u>ELIZA MAE WARNER</u>			2a. DATE OF DEATH Month Day Year <u>Dec. 3 1968</u>		2b. HOUR AM PM <u>4:40 AM</u>
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>Unknown</u>	
6. AGE (In years lost birthday) <u>About 92 YRS.</u>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <u>TALBOT</u>		Md.			
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Memorial</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Laborer</u>	
12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Talbot</u>		13c. CITY OR TOWN <u>Easton</u>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Rt#2, Easton, Maryland</u>			
14. FATHER'S NAME First Middle Last <u>James Roberts</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Alice Sullivan</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <u>216 18 8809</u>		17. INFORMANT Address <u>Percy Warner, Rt#2, Easton, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>486X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>493X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASPIRATION</u> <u>CEREBRAL APOPLEXY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>CEREBRAL APOPLEXY</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>12-5, 1968</u> , to <u>12-3, 1968</u> , that (I) (we) last saw the deceased alive on <u>12-3-1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Richard Tyson, MD.</u>		22c. DATE SIGNED <u>12-4-68</u>	
22d. PHYSICIAN'S NAME (Type) <u>RICHARD TYSON</u>		22e. ADDRESS <u>EASTON Md 21601</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/7/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Coppersville</u>	
23d. LOCATION (City or Town) (County) (State) <u>Coppersville Tal Maryland</u>					
24. FUNERAL DIRECTOR <u>J.B. Washell</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 10 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Richard Judge</u>	

12813

STATE OF TEXAS

COUNTY OF DALLAS

1901

IN SENATE, FEBRUARY 1, 1901.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

RECEIVED BY THE COMMISSIONER OF THE LAND OFFICE.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR 1-15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Alex Middle Ander Last Williams		2a. DATE OF DEATH Month 12 Day 18 Year 68		2b. HOUR 3p M	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH April 3, 1884	
6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH Talbot		Md.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Memorial Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer	
12b. KIND OF BUSINESS OR INDUSTRY		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Talbot	
13c. CITY OR TOWN Easton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 4-Box 148	
14. FATHER'S NAME First Joe Middle William Last		15. MOTHER'S MAIDEN NAME First Rosie Middle Welley Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. 218-30-1554A		17. INFORMANT Address Corya William Easton Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 4270 DUE TO, OR AS A CONSEQUENCE OF (b) UREMIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4341 DUE TO, OR AS A CONSEQUENCE OF (c) CONGESTIVE CARDIAC DISEASE WEEKS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) GENERALIZED ARTERIOSCLEROSIS					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from 11-23-68, to 12-18-68, that (1) (we) lost saw the deceased alive on 12-18-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Richard S. Tyson, M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 12-30-68	
22d. PHYSICIAN'S NAME (Type) RICHARD F. TYSON				22e. ADDRESS EASTON 21601 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12/22/68		23c. NAME OF CEMETERY OR CREMATORY Richards	
23d. LOCATION (City or Town) Easton		(County) Talbot		(State) Md	
24. FUNERAL DIRECTOR Charles H. Nash, Jr. Md. ADDRESS				25a. REC'D BY REGISTRAR DEC 27 1968	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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WASHINGTON, D.C.



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